(Hemi-Sync® Journal, Vol. XXIV, Nos. 1 & 2, Winter-Spring 2006)

PSYCHO-ONCOLOGY AND HEMI-SYNC®

by Jonathan H. Holt, MD

Jonathan H. Holt, MD, graduated from Yale University in 1980 and received Yale's Lidz Prize in psychiatry. Dr. Holt also did his residency at Yale and completed a fellowship in consultation-liaison psychiatry (medical psychiatry) at Mount Sinai Medical Center in New York. He is presently associate professor of psychiatry at State University of New York at Buffalo and co-director of consultation-liaison psychiatry, Department of Psychiatry, School of Medicine, SUNY at Buffalo. Jon is a third-level Reiki practitioner and a practitioner of therapeutic touch and other subtle energy methods. He also utilizes eye movement desensitization reprocessing (EMDR), thought field therapy (TFT), and EEG and peripheral biofeedback. Dr. Holt contributed the article "Hemi-Sync in My Psychiatric Practice" to the summer 2000 issue of the HEMI-SYNC JOURNAL*. He has been a member of TMI's Professional Division since 1996.*

Much of my professional life has been spent in consulting upon and treating people with medical illnesses, with a focus on their psychological and psychiatric problems and reactions. Within this larger group, my particular interest has been patients with cancer, both those in the initial phases of illness and those nearing the end of their earthly lives. Mental health professionals interested in the illnesses and lives of cancer patients have come to be called psycho-oncologists. This field reached a noticeable size in the 1970s, as did the interest in behavioral correlates and treatments of medical illness that was later termed behavioral medicine.

Psycho-oncology primarily refers to psychiatrists working in the field of oncology. A seminal figure in this field is psychiatrist Jimmie Holland, MD. She is married to oncology surgeon James Holland, MD. She worked at the State University of New York at Buffalo through the early '70s. She and her husband moved to New York City in 1974, where she worked at the Albert Einstein College of Medicine in the Bronx and later established the psychiatry department at Memorial Sloan-Kettering Cancer Center. Dr. Holland published "History of Psycho-Oncology: Overcoming Attitudinal and Conceptual Barriers" in the journal *Psychosomatic Medicine* in 2002.[1] While admitting the contributions of psychologists and other nonpsychiatric mental-health workers, she and other psycho-oncological psychiatrists tend to emphasize traditional psychiatric diagnosis and pharmacological treatment. A notable exception to this is the work of William Breitbart, MD, who has designed and fostered existential therapy groups for cancer patients, inspired by the work of Viktor Frankl.[2]

Prior to and during the nineteenth century hypnosis was used by some practitioners for symptom alleviation in various medical disorders, including cancer. Then in the 1950s, ‘60s, and ‘70s, psychologists Hilgard and Hilgard published studies on cancer patients’ response to hypnosis.[3] Psychologists Daniel Brown and Erika Fromm[4] and psychiatrists Herbert and David Spiegel[5] contributed to the use of hypnosis in behavioral medicine. Radiation oncologist Carl Simonton and his wife, Stephanie, developed treatments that were not labeled hypnosis but involved relaxation combined with imagery to address the immune-system aspects of cancer.[6] A Yale surgeon, Bernard (Bernie) Siegel, MD, developed supplementary treatment approaches to cancer that involved relaxation and imagery, as well as music and group support.[7] Dr. Siegel founded Exceptional Cancer Patients (ECAP), an organization that sponsored support groups to help cancer patients cope with the disease. The above work became associated with the notion that cancer patients were responsible for their illness. It’s my understanding that this idea does not represent the beliefs of the aforementioned practitioners. For complex reasons, however, some cancer patients tended to fall into this belief.

Dr. David Spiegel formulated a study with the intent to demonstrate that psychosocial methods could improve the quality of life of cancer patients but would not affect longevity. His intervention consisted of group therapy with an existential focus and added a weekly session of group hypnosis to promote comfort and pain relief. His subjects were breast cancer patients. The control group had a similar diagnosis and received similar treatment without the hypnosis component. To his surprise, the intervention group not only experienced significant improvement in quality of life but experienced significant comparative prolonged survival time. Dr. Spiegel published the study in Lancet in 1989.[8] Since that time six published studies have replicated the longevity findings, but five did not. None of the replication studies included group hypnosis. In addition, I would cite the study by Marilyn Schlitz, PhD, and Richard Wiseman, PhD, published in the Journal of Parapsychology for September 1997. It demonstrated that the beliefs of the experimenter in charge of the experiment could affect the results, even when all other parameters were kept the same.[9] While this study involved parapsychology, the same process may be working in other kinds of phenomena and experiments.

Closer to home, I would point out the work of The Monroe Institute’s Professional Division members and other researchers. Quite a number of the Hemi-Sync exercises have proved useful to patients with cancer. The *SURGICAL SUPPORT* series, exercises to manage pain and encourage relaxation, the *POSITIVE IMMUNITY* series, (originally designed for AIDS patients), and the *GOING HOME* series immediately come to mind. Brian Dailey, MD, an attending physician in emergency room medicine at Rochester General Hospital, uses Hemi-Sync tapes, energy work, and crystals when treating cancer patients. Dr. Dailey collaborated with Monroe Products and The Monroe Institute on the creation of *Chemotherapy Companion* and *Radiation Companion*, which were later combined in the *CANCER SUPPORT* series. At the Seventeenth Professional Seminar, I discussed my use of Hemi-Sync tapes with various

medical patients, including cancer patients and terminally ill patients in the hospice program.[10] Hemi-Sync is very useful to overworked consultation psychiatrists who haven't got the time needed to do many hypnosis sessions or meditation training sessions. Providing Hemi-Sync exercises as "homework" fills the gap.

When I gave that presentation, I was working at St. Peter's Hospital in Albany, New York. I decided to start a research project employing Hemi-Sync with cancer patients. The radiation oncologists were organized into one department and were receptive to cooperating with the psychiatry department. Furthermore, under the medical director, Richard Boehler, the hospital had hired Alicia Recore, PhD, as program director for complementary therapies. Dr. Recore collaborated with me and with radiation oncologists Duncan Savage, MD, Ralph Kiehl, MD, and Todd Doyle, MD. Monroe Products had just introduced *Chemotherapy Companion*. Unfortunately, after consulting with the radiation oncologists, we found that the symptom profile of radiation oncology patients was not well matched by the tape. There is relatively little pain and nausea in this population but much fatigue. There were plans for making a second tape for radiation oncology, but it was not yet ready. Dr. Recore and I consulted with Darlene Miller and Shirley Bliley, and *Energy Walk* was selected as an appropriate alternative. This tape, narrated by Darlene, features guided imagery, with different natural elements—sand and earth, seawater, grass, wind and trees—and the suggestion to absorb the energy of these elements. *Energy Walk* is a good example of indirect suggestion; the listener is free to interpret the symbols in individual and beneficial ways. A protocol was prepared involving daily tape use and a follow-up questionnaire. This protocol was submitted to and approved by the St. Peter's Hospital Internal Review Board.

The process of enlisting willing patients was more complicated than expected. Neither Dr. Recore nor I could be present in the oncology clinic on a regular basis. Explanatory brochures were provided, but recruitment was slow. At this time, due to a change in administration of the hospital, I left employment at St. Peter's Hospital and took a position at SUNY at Buffalo. Dr. Recore and I remained in touch and she continued to oversee the project through June 2004. Twelve patients returned fatigue questionnaires. One patient died before being enrolled in the study. One patient dropped out for unspecified reasons. One patient did not submit data despite follow-up. Four patients reported by phone that *Energy Walk* was helpful for fatigue and pain but did not fill out the questionnaire. As you can see from the table, eleven out of twelve patients found the tape useful for fatigue and eleven out of twelve found the tape useful for relieving pain. Eleven patients listened to the tape once a day. One patient listened to the tape only after radiation treatments (see graph).

The St. Peter's Hospital study illustrates the difficulty in executing clinical research without monetary support or staff. It also illustrates some of the difficulties psychiatrists have in doing clinical research in unstable and uncertain economic environments. Since joining the psychiatry faculty at SUNY at Buffalo, I've been working for four years to get projects going at

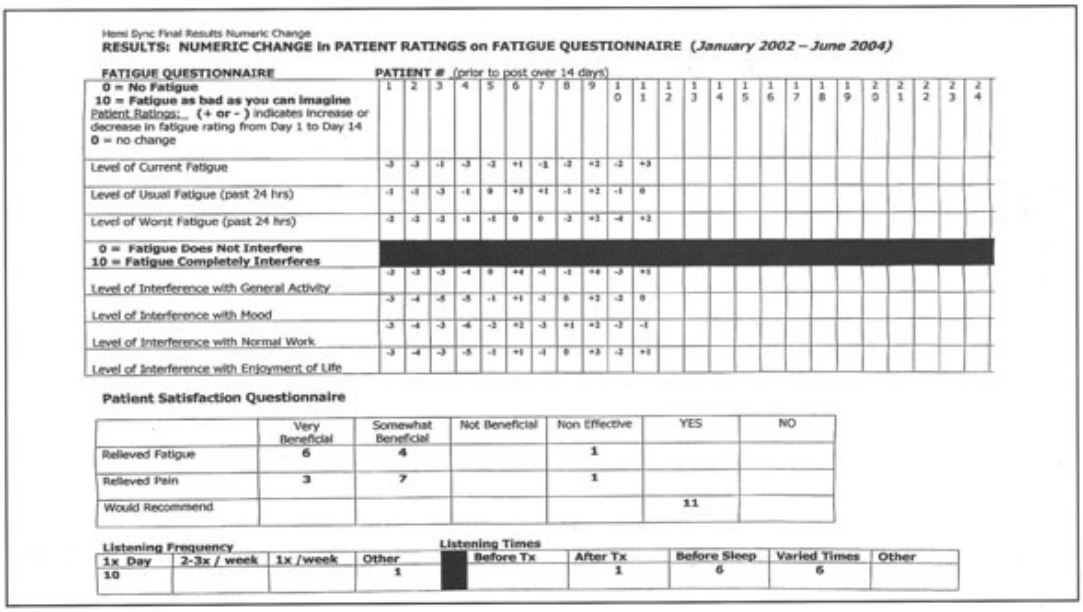
Roswell Park Cancer Institute. I'm scheduled to begin work this spring and have conferred with the chief psychologist to follow up on the Albany pilot study. Whatever cosmic synchronicities were involved, in the same period that we launched the above project, I became involved in a complex case that illustrated many of the issues of psycho-oncology and the usefulness of Hemi-Sync tapes. The case study was published in Psychiatric Services[11] and is excerpted below.

Introduction

Patients at the end of their lives are a special challenge for the psychiatrist, but treatment can encompass all of psychiatric work in a very concentrated form. Neuropsychiatry is featured, with its focus on organic mental status, and affective (emotional) work has important place. Yet many times there is also a call for "existential" work, not only for psychotherapy of various schools, but for psychospiritual therapy—for the transcendent.

Diagnosis of Terminal Illness

Mr. X was eighty years old when he came to psychiatric treatment and died before turning eighty-one. He had been vital and active and was, in fact, still downhill skiing when his final illness manifested. He developed a persistent cough and ascites and was diagnosed with lung cancer. He consented to chemotherapy. Shortly into treatment, however, he developed spinal metastases and began to exhibit signs of spinal cord compression. He was hospitalized for surgical evaluation and relief at an upstate New York hospital. During this hospitalization, the patient learned that his symptoms were not correctable. He would be crippled for the rest of his life, which was estimated at six to nine months.



Hemi Sync Final Results Numeric Change

RESULTS: NUMERIC CHANGE in PATIENT RATINGS on FATIGUE QUESTIONNAIRE ***(January 2002 – June 2004)***

FATIGUE QUESTIONNAIRE **0 = No Fatigue** **10 = Fatigue as bad as you can imagine** Patient Ratings: **(+ or -)** indicates increase or decrease in fatigue rating from Day 1 to Day 14 **0** = no change	PATIENT # (prior to post over 14 days) 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Level of Current Fatigue	-3	-3	-1	-3	-2	+1	-1	-2	+2	-2	+3													
Level of Usual Fatigue (past 24 hrs)	-1	-1	-3	-1	0	+3	+1	-1	+2	-1	0													
Level of Worst Fatigue (past 24 hrs)	-2	-2	-2	-1	-1	0	0	-2	+2	-4	+2													
0 = Fatigue Does Not Interfere **10 = Fatigue Completely Interferes**																								
Level of Interference with General Activity	-2	-3	-3	-4	0	+4	-1	-1	+4	-3	+1													
Level of Interference with Mood	-3	-4	-5	-5	-1	+1	-1	0	+2	-2	0													
Level of Interference with Normal Work	-3	-4	-3	-4	-2	+2	-3	+1	+2	-2	-1													
Level of Interference with Enjoyment of Life	-3	-4	-3	-5	-1	+1	-1	0	+3	-2	+1													

Patient Satisfaction Questionnaire

	Very Beneficial	Somewhat Beneficial	Not Beneficial	Non Effective	YES	NO
Relieved Fatigue	6	4		1		
Relieved Pain	3	7		1		
Would Recommend					11	

Listening Frequency				Listening Times				
1x Day	2-3x / week	1x /week	Other	Before Tx	After Tx	Before Sleep	Varied Times	Other
10			1		1	6	6	

Attempt at Suicide

The patient decided to suicide. He copied the method of a noted physician who had successfully committed suicide in another New York hospital. Mr. X waited until after midnight, well after the change of shift, and then slit his wrists and throat. He was discovered before death, taken to surgery, repaired, and transferred to the intensive care unit.

Consultation

Immediate psychiatric consultation was requested from the author. Mr. X was lucid and courteous. He was slightly puzzled about why he was not being allowed and would not be allowed to complete his suicide. His affect was not overtly depressed. He felt that his suicide attempt was rational given his condition and prognosis. With gentle probing, the patient admitted to recent shifts in sleep and appetite, some anhedonia (inability to feel pleasure), and diurnal variation of mood. I explained that whatever one's individual views on "rational suicide" might be, New York State did not allow the hospital to condone it. Then I explained that for the time that he was in the hospital, the staff would have to try to keep him alive. He was then told that although he had a rationale for suicide, he nevertheless seemed to exhibit some signs of clinical depression and that an antidepressant might relieve some of his suffering. He was quite agreeable. Sertraline® (Zoloft), 100 mg each morning, was prescribed.

Mr. X was invited to talk about his life experiences and their meaning for him, including his illness, which was currently labeled as "terminal." He spoke of the satisfactions during his life, his twin brother, his work, and his enjoyment of sports. He spoke of his fear of loss of control, yet he quickly came to label his suicide attempt "a mistake." I reworded and reframed that label by reiterating that it was the state that limited the ways in which the hospital staff was allowed to respond and that the term "mistake" was not an accurate or useful description of his behavior.

From this point Mr. X was moved to talk about his parents, with whom he had had positive relationships but who had passed away many years before. He volunteered that he believed in a concept of an afterlife and that he believed he would join his parents. He freely offered this belief and acknowledged the comfort that it gave while voicing concerns about the intervening time and events before death. In response to these concerns, I offered a guided meditation series designed for hospice patients.

GOING HOME®

GOING HOME is a two-album series produced by Monroe Products of Lovingston, Virginia. Elisabeth Kübler-Ross, MD, Charles Tart, PhD, and Robert Monroe, the founder of The Monroe Institute, created *GOING HOME*. The tapes use guided meditation techniques with an open, permissive style, but with imagery borrowed from accounts of near-death experiences

and from meditations and trance journeys concerning death and the afterlife. There are no specific images of any one religious group or system. My previous experiences when using these tapes with hospice patients have been successful. Mr. X accepted the offer.

Placement Issues and the Nursing Home

Clinically, the patient healed from his wounds during the next month. His depression syndrome improved on 100 mg per day of Sertraline. The hospital administration believed they were in a precarious situation and at risk for the liability of potential suicide. The patient had promised cooperation, but the circumstances that had created the situation still remained. The administration was reluctant to accept the patient's assurances, as were a number of local nursing homes, including the home officially associated with the hospital. The consultant advised the patient's treatment team to involve the local hospice organization, which was affiliated with the hospital itself. This hospice organization had unfortunately just entered a period of organizational turmoil. At a staff team meeting called to address treatment and placement issues for Mr. X, a hospice administrator stated: "This man must be taught a lesson. There are consequences for his actions." They did not accept the patient, but a brave nursing home near the hospital did. He had agreed to a "no suicide" contract. A nurse clinician from the hospital and I agreed to visit him in his new setting.

The patient started to listen to the *GOING HOME* tapes, and I did some trance exercises with him. Some were adapted from the "conscious dreaming" exercises of Robert Moss[12] and the creative dreaming techniques of Patricia Garfield.[13] Others were adapted from Margaret Cerney's hypnotic work on grief that utilized imagined visits with the dead.[14] I also adapted techniques from *LIFELINE*® graduate and author Bruce Moen[15], who had in turn adapted techniques from The Monroe Institute. Those exercises focused on dreamlike scenarios in which the patient encountered and dialogued with his late parents and other deceased persons of emotional importance. Furthermore, some exercises allowed the patient to explore spontaneous imageries of possible positive afterlife environments. It should be noted that such work does not depend on there being an afterlife or on there being proof of an afterlife—though recent research is thought provoking[16]—but in the interest of the patient in meditating on the subject. Mr. X reported satisfying meditative and trance experiences concerning dying, meeting his parents, and ideas of the afterlife. He reported a cessation of depression symptoms and satisfaction with his life at the nursing home. The nursing home, in turn, reported that the patient was active in physical therapy and other activities. Mr. X became one of the most beloved members of the nursing home community. His twin brother, who lived in a nearby state, visited multiple times despite his own severe illness. The patient reported that he and his brother achieved a sense of closure. About four months after the start of hospitalization, the patient experienced one day of increased weakness, and then died peacefully in his sleep.

Summary

Several principles are demonstrated in this case. “Rational suicide” can have aspects of depressive syndrome, which can respond to traditional pharmacotherapy. Existential or experiential psychotherapy can have a particularly satisfying role in “end of life” therapy. Even organizations dedicated to “end of life” treatment sometimes fall short and can benefit from psychiatric guidance. Where a person’s beliefs render it acceptable, projective work, meditation, and trance work focusing on death and the afterlife can be useful components of therapy. Technological adjuncts, such as the Hemi-Sync tapes in the *GOING HOME* series, can provide useful support, amplify other techniques, and empower patients in the last phase of their lives.

The concluding comment that I would make, overall, is that there is an important role for psychiatrists and Hemi-Sync in cancer care and research, though the road is filled with obstacles and detours.

References

1. J. Holland, “History of Psycho-Oncology: Overcoming Attitudinal and Conceptual Barriers,” Psychosomatic Medicine 64, no. 2 (2002): 206–21.

2. W. Breitbart, “Spirituality and Meaning in Supportive Care: Spirituality- and Meaning-Centered Group Psychotherapy Interventions in Advanced Cancer,” Supportive Care in Cancer 10, no. 4 (2002): 272–80.

3. E. Hilgard and J. Hilgard, Hypnosis in the Relief of Pain (Los Altos, CA: William Kaufmann, Inc., 1975).

4. D. Brown and E. Fromm, Hypnosis and Behavioral Medicine (Hillsdale, NJ: Lawrence Erlbaum Associates, 1987).

5. H. Spiegel and D. Spiegel, Trance and Treatment: Clinical Uses of Hypnosis (New York: Basic Books, 1978).

6. O. C. Simonton, S. Simonton, and J. Creighton, Getting Well Again (Los Angeles: J. P. Tarcher, 1978).

7. B. Siegel, Love, Medicine, and Miracles (New York: Harper Collins, 1986).

8. D. Spiegel, J. R. Bloom, H. C. Kraemer, and E. Gottheil, “Effect of Psychosocial Treatment on Survival of Patients with Metastatic Breast Cancer,” Lancet no. 2 (Oct. 14, 1989): 888–91.

9. R. Wiseman and M. Schlitz, “Experimenter Effects and the Remote Detection of Staring,” Journal of Parapsychology 61, no. 3 (1997): 197–208.

10. J. Holt, “Hemi-Sync in My Psychiatric Practice,” Hemi-Sync Journal 17, no. 3 (2000).

11. J. Holt, “Practical Geriatrics: Psychiatry and Spirituality at the End of Life: A Case Report,” Psychiatric Services 55, no. 6 (June 2004): 618–22.

12. R. Moss, Conscious Dreaming: A Spiritual Path for Everyday Life (New York: Random House, 1996).

13. P. Garfield, Creative Dreaming (New York: Fireside, 1974).

14. M. S. Cerney, Presentation at the Annual Scientific Meeting of the Society for Clinical and Experimental Hypnosis, St. Louis, MO, Nov. 1989.

15. B. Moen, Voyages into the Unknown, vol. 1 of Exploring the Afterlife (Charlottesville, VA: Hampton Roads, 1997).

16. G. Schwartz et al., “Accuracy and Replicability of Anomalous After-Death Communication across Highly Skilled Mediums,” Journal of the Society for Psychical Research 65, no. 1 (2001): 1–25.